Ontario

Inspection Report Under the
Fixing Long-Term Care Act, 2021

Ministry of Long-Term Care
Long-Term Care Operations Division
Long-Term Care Inspections Branch

Toronto District
5700 Yonge Street, 5th Floor
Toronto, ON, M2M 4K5
Telephone: (866) 311-8002

Original Public Report

Report Issue Date: June 22, 2023

Inspection Number: 2023-1538-0003

Inspection Type:
Follow up
Critical Incident System

Licensee: City of Toronto

Long Term Care Home and City: Cummer Lodge, North York

Lead Inspector	**Inspector Digital Signature**
Henry Chong (740836)	Henry A Chong Digitally signed by Henry A Chong Date: 2023.06.26 15:17:18 -04'00'

Additional Inspector(s)
Arther Chandramohan (000720)
Reji Sivamangalam (739633)

INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): June 8-9, 12-16, 2023

The following intake(s) were inspected:

- Intake: #00084845 - [CI: M512-000010-23] Staff to resident physical abuse
- Intake: #00086060 - Follow-up related to plan of care
- Intake: #00087146 - [CI: M512-000014-23] - Fall with injury
- Intake: #00087305 - [CI: M512-000015-23] - Resident to resident physical abuse

The following intake(s) were completed in this inspection:

- Intake: #00088416 - [CI: M512-000017-23] - Fall with injury

Previously Issued Compliance Order(s)

The following previously issued Compliance Order(s) were found to be in compliance:
Order #001 from Inspection #2023-1538-0002 related to FLTCA, 2021, s. 6 (7) inspected by Henry Chong (740836)

The following **Inspection Protocols** were used during this inspection:

Food, Nutrition and Hydration
Infection Prevention and Control
Prevention of Abuse and Neglect
Responsive Behaviours
Falls Prevention and Management

INSPECTION RESULTS

WRITTEN NOTIFICATION: Plan of care

NC #001 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 6 (7)

The licensee has failed to ensure that an intervention was provided to resident #004 as per the plan of care.

Rationale and Summary
Resident #004 had responsive behaviours and a history of altercations with others.

The Behavioral Support Resource Team (BSRT) nurse and Nurse Manager stated that the resident always required an intervention in place to prevent altercations with others and is part of their written plan of care.

On an identified date, an intervention was not in place for resident #004. As a result, resident #004 was involved in an altercation with another resident.

A PSW verified that the intervention was not in place for resident #004 at the time of the incident.

The Nurse Manager confirmed that the intervention was not provided to resident #004 as required by the plan of care.

Failure to ensure that the intervention was provided as per the plan of care for resident #004 put the

other residents at risk of harm.

Sources: Home's policy of Behavioral Response Care-Strategies (#RC-0517-00, Published on 15-09-2022), resident #004's written plan of care, progress notes and clinical records, home's investigation notes, interview with PSW, BSRT Nurse and NM.

[739633]

WRITTEN NOTIFICATION: Duty to protect

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.
Non-compliance with: FLTCA, 2021, s. 24 (1)

The licensee has failed to ensure that resident #003 was protected from physical abuse by resident #004.

Section 2 of the Ontario Regulation 246/22 defines physical abuse as "the use of physical force by a resident that causes physical injury to another resident."

Rationale and Summary
A Critical Incident (CI) report was received by the Ministry of Long-Term Care (MLTC) about an incident on a specified date, where resident #004 and resident #003 were involved in a physical altercation. Resident #003 sustained injuries as a result of the altercation.

A PSW stated that they had witnessed the physical altercation between resident #004 and resident #003. Resident #003 required interventions.

A Nurse Manager (NM) verified that resident #003 was physically abused by resident #004.

Sources: Home's policy of Zero Tolerance of Abuse and Neglect (#RC-0305-00, Published on 01-06-2021), CIS Report #M512-000015-23, residents' progress notes and clinical records, home's investigation notes, interview with PSW and NM.

[739633]

COMPLIANCE ORDER CO #001 Transferring and positioning techniques

NC #003 Compliance Order pursuant to FLTCA, 2021, s. 154 (1) 2.
Non-compliance with: O. Reg. 246/22, s. 40

The inspector is ordering the licensee to comply with a Compliance Order [FLTCA, 2021, s. 155 (1) (a)]:
The licensee shall:
1. Complete audits of a type of resident transfers on each day and evening shift for a period of 14 days following the service of this order. The audits shall be completed on an identified unit to ensure that safe transferring techniques are used when assisting residents.
2. Maintain a record of audits completed, to include but not limited to: person(s) who conducted the audits, time and date, resident and staff audited, results of the audits and any actions taken in response to the audit findings.

Grounds
The licensee has failed to ensure that staff used safe transferring techniques when assisting a resident.

Rationale and Summary
On an identified date, a PSW attempted to transfer the resident. The resident fell and was hospitalized, and sustained an injury.

The resident's plan of care indicated that they required a specific intervention when transferring. The intervention was not implemented at the time of the incident.

The PSW acknowledged that the intervention was not implemented. RN and NM stated that the intervention was not provided and that the care plan was not followed.

Failure to transfer the resident as per the plan of care resulted in the resident falling and sustaining injury.

Sources: Facility's investigation notes; interview with PSW, RN, and Nurse Manager; facility's Falls Prevention Policy; review of resident #002's progress notes in Point Click Care (PCC) and the resident's plan of care.

[000720]

This order must be complied with by August 2, 2023

REVIEW/APPEAL INFORMATION

TAKE NOTICE
The Licensee has the right to request a review by the Director of this (these) Order(s) and/or this Notice of Administrative Penalty (AMP) in accordance with section 169 of the Fixing Long-Term Care Act, 2021 (Act). The licensee can request that the Director stay this (these) Order(s) pending the review. If a licensee requests a review of an AMP, the requirement to pay is stayed until the disposition of the review.

Note: Under the Act, a re-inspection fee is not subject to a review by the Director or an appeal to the Health Services Appeal and Review Board (HSARB). The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order or AMP was served on the licensee.

The written request for review must include:

(a) the portions of the order or AMP in respect of which the review is requested;
(b) any submissions that the licensee wishes the Director to consider; and
(c) an address for service for the licensee.

The written request for review must be served personally, by registered mail, email or commercial courier upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

If service is made by:
(a) registered mail, is deemed to be made on the fifth day after the day of mailing
(b) email, is deemed to be made on the following day, if the document was served after 4 p.m.
(c) commercial courier, is deemed to be made on the second business day after the commercial courier received the document

If the licensee is not served with a copy of the Director's decision within 28 days of receipt of the licensee's request for review, this(these) Order(s) is(are) and/or this AMP is deemed to be confirmed by the Director and, for the purposes of an appeal to HSARB, the Director is deemed to have served the licensee with a copy of that decision on the expiry of the 28-day period.

Pursuant to s. 170 of the Act, the licensee has the right to appeal any of the following to HSARB:
(a) An order made by the Director under sections 155 to 159 of the Act.
(b) An AMP issued by the Director under section 158 of the Act.
(c) The Director's review decision, issued under section 169 of the Act, with respect to an inspector's compliance order (s. 155) or AMP (s. 158).

HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the licensee decides to request an appeal, the licensee must give a written notice of appeal within 28 days from the day the licensee was served with a copy of the order, AMP or Director's decision that is being appealed from. The appeal notice must be given to both HSARB and the Director:

Health Services Appeal and Review Board
Attention Registrar
151 Bloor Street West, 9th Floor
Toronto, ON, M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Long-Term Care
438 University Avenue, 8th Floor
Toronto, ON, M7A 1N3
e-mail: MLTC.AppealsCoordinator@ontario.ca

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal and hearing process. A licensee may learn more about the HSARB on the website www.hsarb.on.ca.